14234772311 P 18/24

8652125642 >> DC0547PM13501

DEPAR	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED
) STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG 01 - LIFE CARE CENTER OF GRAY	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		445479	B. WING_		08/20/2013
ĺ	PROVIDER OR SUPPLIER ARE CENTER OF GRAY			STREET ADDRESS, CITY, SYATE, ZIP CODE 791 OLD GRAY STATION ROAD GRAY, TN 37615	1 00/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	BE COMPLETION
K 018 \$S=D	Doors protecting correquired enclosures hazardous areas are those constructed or wood, or capable of minutes. Doors in singular to resist the no impediment to the are provided with a repermitted.	ridor openings in other than of vertical openings, exits, or a substantial doors, such as f 1½ inch solid-bonded core resisting fire for at least 20 prinklered buildings are only a passage of smoke. There is a closing of the doors. Doors means suitable for keeping tch doors meeting 19.3.6.3.6 3.6.3 ohibited by CMS regulations littles.	K 014	1. What corrective actions will be accomplished for those residents for to have been affected by the deficient practice? a) No residents were affected 2. How will you identify other reside that have the potential to be affected the alleged deficient practice and whete corrective action will be taken. a) All residents have the potential to affected 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Corridor door to resident room 112 immediately fixed to positive latch the adjusting hinges by Maintenance Director on 8/20/2013. Drill will be conducted once weekly for three most to ensure these doors close to a positilatch. 4. How the corrective action(s) will be	ents I by hat be ace Oy nths ive
	Based on observatio failed to assure corric positive latch The findings include:	View with the Maintenance		monitored to ensure the deficient practice will not recur and what qual assurance program will be put in plat. The Maintenance Director will report the findings of the audit to the performance improvement committe for three months. The performance improvement	ity ce? t
	confirmed corridor do failed to close to a po This finding was verifi Supervisor and ackno Administrator during t August 20, 2013.	or to resident room 112 sitive latch. ed by the Maintenance	K 021	committee will review the results. If is deemed necessary by the committee additional education may be provided the process evaluated/revised and/or audits reviewed, for three months or until 100% compliance is achieved.	ee, d;

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE Executive bivector

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

EvenLID: CCNL21

Facility IO: YN9010

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

14604/16011 P 17/64

PRINTED: 08/22/2013 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - LIFE CARE CENTER OF GRAY 445479 B. WING 08/20/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 791 OLD GRAY STATION ROAD LIFE CARE CENTER OF GRAY GRAY, TN 37615 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE (X4) ID PREFIX ID PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1. What corrective actions will be K 021 | Continued From page 1 K 021 10/05/2013 accomplished for those residents found to have been affected by the deficient practice? SS=E No residents were affected Any door in an exit passageway, stairway 2. How will you identify other residents that enclosure, horizontal exit, smoke barrier or have the potential to be affected by the hazardous area enclosure is held open only by alleged deficient practice and what corrective devices arranged to automatically close all such action will be taken. doors by zone or throughout the facility upon All residents have the potential to be affected activation of: 3. What measures will be put into place or what systematic changes will you make to a) the required manual fire alarm system; ensure that the deficient practice does not recur? b) local smoke detectors designed to detect Door to physical therapy near transitional smoke passing through the opening or a required rehab and corridor fire doors to the dining smoke detection system; and room immediately fixed to positive latch by adjusting hinges by Maintenance Director on c) the automatic sprinkler system, if installed. 8/20/2013. Hinges replaced on kitchen fire 19.2.2.2.6. 7.2.1.8.2 doors on 9/3/13 and now close to a positive latch. Drill will be conducted once weekly for three months to ensure these doors close to a positive latch. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance This STANDARD is not met as evidenced by: program will be put in place? Based on observation and interview, the facility The Maintenance Director will report the failed to assure corridor fire doors would close to findings of the audit to the performance a positive latch. improvement committee for three months. The findings include: The performance improvement committee will review the results. If it is deemed Observation and Interview with the Maintenance Director, on August 20, 2013 at 10:40 a.m. necessary by the committee, additional confirmed the following corridor fire doors would education may be provided; the process evaluated/revised and/or the audits reviewed. not close to a positive latch: door to Physical for three months or until 100% compliance is Therapy near transient rehab room, Kitchen fire achieved. doors to the dining room, and corridor fire doors at the entrance to the dining room. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

8652125642 >> 14234772311 P 20/24

PRINTED: 08/22/2013

FORM APPROVED

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 445479 8. WING STREET ADDRESS, CITY, STATE, 29 CODE 73 OLD GRAY STATION ROAD GRAY, TN 37615 SUMMAY STATION ROAD GRAY, TN 37615 IDENTIFICATION NUMBER: TAG ISLAMMAY STATION ROAD GRAY, TN 37615 IDENTIFICATION SHOULD BE CONSTRUCTED BY TAG K 029 CONTINUED FROM LIFE SAFETY CODE STANDARD One hour fire rated construction (with ½ hour fire-rated doors) or an approved automatic fire exitinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous aroses. When the approved automatic fire exitinguishing system option is used, the areas are separated from other spaces by moke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility falled to assure rooms larger than 50 square feet, used to store combustible materials, were provided with door closers. The findings include: Observation and interview with the Maintenance Director, on April 18, 2013 at 1:15 p.m. confirmed the Medical records storage room and the Staff Development office doors one only provided with door closers. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013. K 045 K 046 Illumination of means of egress, including exit discharge, is arranged so that failure of any single with the weight of these residents that the section processed and or the audit to the provised and the audit to the provised of the section of the audit of the section of the audit of the section of the audit of the provised. The provised in the provised of the section of the audit of the section of the audit of the provised. The provised of the section of the audit of the provised of the section of the audit of the provised. The pro	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-0391
STREET ADDRESS, CITY, STATE, 2IP CODE 791 OLD GRAY STATION ROAD CRAY, TN 37619 CRAY	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE_JIP CODE TO GRAY TRATION ROAD GRAY, TN 37613 TO GRAY TRATION ROAD GRAY, TN 37613 PROFINE TAGE CONTROLLED THE REGULATION OR LISC DENTIFYING INFORMATION) PREFIX TAGE CONTROLLED THE REGULATION OR LISC DENTIFYING INFORMATION) PREFIX TAGE CONTROLLED THE REGULATION OR LISC DENTIFYING INFORMATION) TO THE APPROPRIATE CONTROLLED THE REGULATION OR LISC DENTIFYING INFORMATION OR LISC DENTIFY THE PREPARENT OF THE APPROPRIATE CONTROLLED THE APPROPRIATE CONTROLLED THE PREPARENT OF THE APPROPRIATE CONTROLLED THE APPROPRIATE CO		<u> </u>	445479	B, WING	·····	08/20/2013
INTERIOR CENTER OF GRAY (KA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL) TAG K 029 CONTINUED From page 2 K 029 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ½ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system in extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure rooms larger than 50 square feet, used to store combustible materials, were provided with door closers. The findings include: Observation and interview with the Maintenance Director, on April 18, 2013 at 1:15 p.m. confirmed the Medical records storage room and the Staff Development office doors were not provided with door closers. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013. K 045 Illumination of means of egress, including exit discharge, is arranged so that failure of any single residents to the potential to be affected by the deficient practice? No residents were affected by the deficient practice 2. How will voil identify other residents that have the potential to be affected 2. How will voil identify other residents that have the potential to be affected 2. How will voil identify other residents that have the potential to be affected by the maintenance Director will report the findings of the audit to the performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the provenent committee will review the results. If it is deemed necessar	NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/24 10
REGULATORY OR LSC IDENTIFYING INFORMATION) K 029 Continued From page 2 K 029 K	LIFE CA	RE CENTER OF GRAY	•	[;	791 OLD GRAY STATION ROAD	
K 029 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¼ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied proteotive plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure rooms larger than 50 square feet, used to store combustible materials, were provided with door closers. The findings include: Observation and interview with the Maintenance Director, on April 18, 2013 at 1:15 p.m. confirmed the Medical records storage room and the Staff Development office doors were not provided with door closers. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013. K 045 SS=E Illumination of means of egress, Including exit discharge, is arranged so that failure of any single letter future of the base of the staff to hour shall be the finding of the aedical for those sesidents found to have been affected by the deficient practice? No residents were affected 2. How will you identify other residents that have the potential to be affected by the deficient practice and what corrective action will be affected by the deficient practice? No residents were affected 2. How will you identify other residents found to have been affected by the deficient practice? No residents were affected 2. How will you identify other residents found to ensure the deficient practice does not recur? Door suit be spot checked once a week to ensure the closure reain functional. 4 How the corrective action(s) will be monitored to ensure the closure reain functional. 4 How the corrective action(s) w	PREFIX	·	' MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX	D BE COMPLETION
This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure rooms larger than 50 square feet, used to store combustible materials, were provided with door closers. The findings include: Observation and interview with the Maintenance Director, on April 18, 2013 at 1:15 p.m. confirmed the Medical records storage room and the Staff Development office doors were not provided with door closers. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on August 20, 2013. K 045 SS=E Illumination of means of egress, Including exit discharge, is arranged so that failure of any single lighting fictions (highly will be at large the series).	K 029	One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 proton the approved automoption is used, the approved other spaces by sm doors. Doors are stilled-applied protect 48 inches from the light of the state of the st	construction (with ¼ hour an approved automatic fire in accordance with 8.4.1 sects hazardous areas. When natic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or live plates that do not exceed pottom of the door are	-	accomplished for those residents found have been affected by the deficient practice. No residents were affected. 2. How will you identify other resident have the potential to be affected by the alleged deficient practice and what correction will be taken. All residents have the potential to be affected by the assures will be put into place what systematic changes will you make ensure that the deficient practice does a recur? Door closures installed on the medical record storage room and staff developm office doors on 9/3/13. Doors will be spot checked once a week	ectice? s that ective fected or to of
August 20, 2013. K 045 NFPA 101 LIFE SAFETY CODE STANDARD SS=E Illumination of means of egress, Including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not larger the care in the potential to be affected by the potential to be affected by the potential to be affected by the	1	Based on observatifailed to assure roor used to store combuprovided with door of the findings include Observation and interpretor, on April 18, the Medical records Development office door closers. These findings were Supervisor and acknowledged to a store of the second of the secon	on and Interview, the facility ins larger than 50 square feet, istible materials, were losers. Erview with the Maintenance 2013 at 1:15 p.m. confirmed storage room and the Staff doors were not provided with verified by the Maintenance lowledged by the		4.How the corrective action(s) will be monitored to ensure the deficient practic will not recur and what quality assurance program will be put in place? The Maintenance Director will report the findings of the audit to the performance improvement committee for three month. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviet for three months or until 100% compliant.	e ess. ee
alleged delicient practice and what corrective	K 045 \$\$⊂E	Administrator during August 20, 2013. NFPA 101 LIFE SAF Illumination of means discharge, is arrange	the exit conference on ETY CODE STANDARD s of egress, Including exit ad so that failure of any single	K 045	accomplished for those residents found have been affected by the deficient pra No residents were affected 2. How will you identify other resident	s that

FORM CMS-2567(02-99) Previous Versions Obsolete

Fecility ID: TN9010

If continuation sheet Page 3 of 6

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		AND HUMAN SERVICES			FORM APPROVE
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445479		(X2) MULTIP A. BUILDING	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		8, WING_	08/20/2013		
	PROVIDER OR SUPPLIER RECENTER OF GRA	Y		STREET ADDRESS, CITY, STATE, ZIP CODE 791 OLD GRAY STATION ROAD GRAY, TN 37615	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
SS=E	darkness. (This do lighting in accordant lighting in accordant lighting in accordant lighting in accordant lighting ligh	es not refer to emergency ce with section 7.8.) 19.2.8 s not met as evidenced by: ion and interview, the facility s paths to the public way was ig. erview with the Maintenance 20, 2013 at 11:35 a.m. de lights at the side exits from the building and front/side with egress lighting such that igle lighting fixture (bulb) area in darkness (NFPA 101. iffied by the Maintenance nowledged by the the exit conference on ETY CODE STANDARD sprinkler systems are lined in reliable operating	K 045	All residents have the potential to be affe 3. What measures will be put into place of what systematic changes will you make the ensure that the deficient practice does not recur? Lights added at the side exits from station Lights will be checked once weekly to ensure they are still functional for three months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? The Maintenance Director will report the findings of the audit to the performance improvement committee for three month. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits revier for three months or until 100% compliant achieved. 1. What corrective actions will be accomplished for those residents found have been affected by the deficient practice. 1. What corrective actions will be accomplished for those residents found have been affected by the deficient practice. How will you identify other resident have the potential to be affected by the alleged deficient practice and what correction will be taken.	e do
	Based on observation			All residents have the potential to be af 3. What measures will be put into place what systematic changes will you make ensure that the deficient practice does recur? 2 sprinkler heads will be replaced to be response heads on 9/13/13 to ensure all sprinkler heads outside the social service.	or to tot quick three

DEPARTMENT OF HEALTH AND HUMAN SERVICES

14234772311 P 22/24

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FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER; A. BUILDING 01 - LIFE CARE CENTER OF GRAY COMPLETED 445479 B. WING 08/20/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF GRAY 791 OLD GRAY STATION ROAD GRAY, TN 37615 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) office are quick response heads. K 062 : Continued From page 4 Will check once weekly to verify these K 062; sprinkler heads are still in place for three 1. Observation and interview with the months. maintenance director in the compartment outside 4. How the corrective action(s) will be the Social Services office, on August 20 at 8:50 monitored to ensure the deficient practice a.m. confirmed only one (1) of three (3) sprinkler will not recur and what quality assurance heads were quick response heads. program will be put in place? 2. . Observation and interview with the The Maintenance Director will report the Maintenance Director on August 20 at 1:50 p.m. findings of the audit to the performance confirmed wires supported by sprinkler piping in improvement committee for three months. the attic by room 306 and above the laundry The performance improvement committee corridor. will review the results. If it is deemed These findings were verified by the Maintenance necessary by the committee, additional Supervisor and acknowledged by the education may be provided; the process administrator during the exit conference on evaluated/revised and/or the audits reviewed. August 20, 2013. for three months or until 100% compliance is K 067 NFPA 101 LIFE SAFETY CODE STANDARD achieved. K 067 10/05/2013 \$\$=E 1. What corrective actions will be Heating, ventilating, and air conditioning comply accomplished for those residents found to with the provisions of section 9.2 and are installed have been affected by the deficient practice? in accordance with the manufacturer's No residents were affected specifications. 19.5.2.1, 9.2, NFPA 90A, 2. How will you identify other residents that 19.5.2.2 have the notential to be affected by the alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected 3. What measures will be put into place or This STANDARD is not met as evidenced by: what systematic changes will you make to ensure that the deficient practice does not NFPA 90A, 3-4.7 Maintenance - At least every 4 recur? years, fusible links (where applicable) shall be All fire dampers identified and labeled. 4 removed; all dampers shall be operated to verify year required maintenance performed on all that they fully close; the latch, if provided, shall be dampers. Dampers will be spot checked once checked; and moving parts shall be lubricated as weekly to ensure functionality for three necessary. months. Based on observation, interview and record 4. How the corrective action(s) will be review, the facility failed to assure fire dampers monitored to ensure the deficient practice were maintained in accordance with NFPA 90A. will not recur and what quality assurance The findings include: program will be put in place? Observation during the building tour on August The Maintenance Director will report the 20, 2013 between 9:45 a.m. and 1:30 p.m. findings of the audit to the performance improvement committee for three months.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

8652125642 >> 14234772311 P 23/24

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FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - LIFE CARE CENTER OF GRAY			(X3) DATE SURVEY COMPLETED	
	445479	B. WING		0.0	3/20/2013	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF GRAY			STREET ADDRESS, CITY, STATE, ZIP CODE 791 OLD GRAY STATION ROAD GRAY, TN 37615			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST 8E PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE	
Record review and Maintenance Direct p.m. confirmed the required maintenand dampers. This finding was well Supervisor and act Administrator during August 20, 2013. K 072 NFPA 101 LIFE SAME SEED Means of egress at of all obstructions use in the case of furnishings, decorate exits, access to, egreen access to a series were maintally (NFPA 101- 7.1.10). The findings included Conservation and in Director, on August confirmed the launce linen carts, floor do personal belonging This finding was veriation and server the segress and belonging this finding was veriated.	fire dampers were observed. If interview with the ctor on August 20, 2013 at 1:30 or facility performed the 4-year nace to twelve (12) fire erified by the Maintenance knowledged by the ng the exit conference on AFETY CODE STANDARD are continuously maintained free or impediments to full instant fire or other emergency. No atlons, or other objects obstruct gress from, or visibility of exits, since the standard of the facility corridors in the means of since clear of all obstructions 2.1.) e: terview with the Maintenance 20, 2013 at 1:50 p.m. Ify wing corridor had clean the sthroughout the corridor, or ified by the Maintenance	K 06	7 The performance improvement commi will review the results. If it is deemed necessary by the committee, additional education may be provided; the proces evaluated/revised and/or the audits rev for three months or until 100% compliachieved. 1. What corrective actions will be accomplished for those residents found	to to tice? s that ective fected or to to to col ing ctor col ing ctor col ing ctor col ing ctor col ing	10/05/2013	
	Supervisor and acknowledged by the administrator during the exit conference on August 20, 2013.		necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits revided for three months or until 100% compliants achieved.	ewed,		